Grady

Office of Research Administration
Medical Record Number (MRN) Request Form

Instructions:

- Please provide typed responses. Written responses are **not** permitted.
- Submit completed form to research@gmh.edu for processing.
- Please allow 48 hours from the date of submission for an update.

Current forms are available on the **ORA Webpage**

Request Date_____

IRB Number: _____

Demographics Needed:

Patient's Legal Name: _____Marital Status_____
Date of Birth: _____& SSN#_____
E-Mail Address: _____
Current Address: _____
City, State, Zip: _____
Mobile/Home Phone: _____
Emergency Contact Name & Number: _____
Veteran Status: Y/N_____
Gender (Male or Female): _____Race: _____

Acceptable forms of ID:

- Georgia Driver's License
- Georgia ID
- Driver's License- Out of State
- Valid Employer ID Card
- Resident Alien Card or Immigration Document issued by U.S. Government
- Certification of Identity = (COI)

Please attach a copy of ID along with form.

Grady

CERTIFICATION OF IDENTITY

I hereby certify that my name is _____ and my date of birth is _____. I further certify that my current address is _____

_____.

I acknowledge that I am to provide appropriate identification at my next appointment. Acceptable forms of identification include, but are not limited to the following:

Georgia Driver's License	Resident Alien Card or Other Immigration Document Issued by the U.S. Government
Georgia Identification Card	Valid Employer Identification Card
Out of State Driver's License	U.S. Passport
Out of State Identification Card	Picture School Identification Card
Employment Authorization Card	Housing Authority Identification Card
Military Identification Card	Visitor Visa
Any Consular Identification Card	Birth Certificate (newborns and children only)
Other Identity Document	

I hereby certify that the information I have provided is true and correct.

_____ _____ _____

Signature of Patient or Patient Representative **Witness** **Date**

Translator: _____ ☐ Telephone ☐ In-Person

If patient is a minor complete the following: Patient is a minor of _____ years of age or is unable to complete this form because _____.

_____ _____ _____

Signature of Closest Relative/Relationship or Legal Guardian **Witness** **Date**

Social Services Use Only: Stat Pack# _____ Patient's Name: _____

Identification Source	**Validation Documentation/Comments**
Patient Valuables: Georgia Driver's License, Georgia ID or Out-of State License/ID	
Finger Print/Missing Person:	
Family Member:	
Shelter Personnel:	
Other:	

_____ Contacted/Extension-FAX#: _____

Signature of Social Worker/Date Employee Name/Rec'd/Update: _____

7/09, 10/11, 6/14, 12/14

AFFIX LABEL